Wisconsin Department of Safety and Professional Services

Mail To: P.O. Box 8935
Madison, WI 53708-8935
FAX #: (608) 251-3036
Phone #: (608) 266-2112

Ship To: 4822 Madison Yards Way
Madison, WI 53705
E-Mail: dsps@wisconsin.gov
Website: http://dsps.wi.gov

COSMETOLOGY EXAMINING BOARD

EMPLOYMENT VERIFICATION

APPLICANT: Complete top portion of this form and forward to past or present employer. Proper completion of this form is required for processing of the application. Failure to submit proper documentation of employment will delay processing of your credential application.

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**

Address (street, city, state, zip)

Date of Birth __/__/____

I hereby authorize the employer named below to provide the Department with the information requested below.

Applicant Signature: _____ Date: __/__/____

PAST OR PRESENT EMPLOYER: Certify employment below and return directly to DSPS. You may fax/email to: (608) 251-3036 or DSPSCREDBAC@wisconsin.gov.

Cosmetology Manager/Owner Name

Check One: ☐ Cosmetology Manager ☐ Owner

Establishment Name

Establishment License Number

Establishment Address (street, city, state, zip)

Employment Period: (include month, day, and year) From: __/__/__ To: __/__/__

Hours Worked: ☐ Full-Time Number of Hours Per Week:

☐ Part-Time Number of Hours Per Week:

Total Numbers of Hours Worked:

Employee Worked as: (check one) ☐ Aesthetician ☐ Cosmetologist ☐ Electrologist ☐ Manicurist

I declare, as the Cosmetology Manager or Owner, the foregoing statements are true to the best of my knowledge and belief, and that I personally completed and signed this form.

Signature of Cosmetology Manager or Owner

Date __/__/____

Address (street, city, state, zip)

License Number:

Committed to Equal Opportunity in Employment and Licensing